People's Health Movement's reply to questions raised by members of the Portfolio Committee on Health

21 February 2022

We thank the Committee for the overall quality of the questions. We have endeavored to provide evidence-based and well-referenced replies to all of them. Where questions from different members look at a key issue from different angles, we address the topic comprehensively in one place and link back to it when it comes up again from a different member. However, some repetition is unavoidable.

PHM SA would also like to declare that we have no conflict of interest in the NHI Bill.

Questions from Ms Anna Gela

QUESTION 1: For the comprehensive presentation, may I request further clarity from people's health movement regarding their statement that certain the provisions of the initial Bill will continue to marginalize members of the civil society.

PHM reply

- For the purposes of this reply we define civil society **(CS)** as

  "*groups or organizations working in the interest of citizens but operating outside of the governmental and for-profit (market) sectors. Organizations and institutions that make up civil society include labor unions, non-profit organizations, churches, and other service agencies that provide an important service to society but generally ask for very little in return*"[1]. They are accountable to the citizens whose interests they represent.

- In the NHI White paper (Version 40, Dec 2015), there was a lot of discussion about the role of Civil Society. The White Paper explicitly acknowledged the role of Civil Society in addressing TB and HIV in South Africa in the past and foresaw a big role for Civil Society in the NHI. For example, it included Civil Society in the composition of the NHI Commission (para 328) which was to govern the NHI fund.

- Two years later, the 2017 NHI White Paper placed Civil Society in the NHI Board, which was conceived not as a stakeholder representative body but a Board with governance powers that would ensure a functional, effective and accountable NHI fund. (para 255 to 256)

- This means that in both the policy documents that preceded the Bill, Civil Society was seen as playing an important governance role, ensuring oversight. This is explicit in both White Papers.
- In the 2019 NHI Bill, however, civil society are effectively demoted to participate in a stakeholder representative body called the Stakeholder Advisory Committee (SAC), along with representatives from the statutory health professions councils, health public entities, organised labour and other entities. (NHI Bill Chapter 7 paragraph 27).
- The Stakeholder Advisory Committee (SAC) is the only structure in the Bill where civil society has a presence. (Chapter 7.27) This is a far cry from the roles envisaged for civil society in the two white papers.
- We further believe that the Bill effectively marginalises civil society because the Minister has, for all practical purposes, complete power to select, appoint, and fire members of the Committee:

  > *"The Minister must, after consultation with the Board and by notice in the Gazette, appoint a Stakeholder Advisory Committee comprised of representatives from the statutory health professions councils, health public entities, organised labour, civil society organisations, associations of health professionals and providers as well as patient advocacy groups in such a manner as may be prescribed". (Chapter 7.27).*

- There is no clarity about, for example, which "health public entities", unions, civil society organisations, professional associations or patient advisory groups the Minister will select. The Minister is therefore free to appoint members of organisations of his or her choice rather than true representatives of citizen groups who work in the interests of — and are accountable to — their members and the citizens whose interests they represent. It is likely that entities with vested interests will lobby to ensure that parties favourable to their interests secure representation on this structure – we have seen in WHO forums that industry interests are expressed through bodies purported to represent civil society when these bodies are really just fronts for industry. There is likely, therefore, to be pressure on the minister to ensure that vested interests are represented in the structure.
- It's important to note here that the Board is also appointed by, and accountable to, the Minister. So, many of these problems may also apply to the NHI Board.
- Finally, unlike the other Advisory Committees Established by the Minister, the Bill contains no description of the function and duties of the SAC.
- PHM feels that the above process gives the Minister too much power over the workings and composition of the SAC. Having been appointed by the Minister, members of the SAC might see themselves as primarily accountable to the Minister rather than to the constituencies they are supposed to represent. They may be reluctant to raise and debate controversial issues openly. They may even fear being removed from the Committee if they say things the Minister does not like. The SAC will therefore not be

easily able to advise the Minister in ways that best serve the interests of the population. It is a weak structure for community voice, will not ensure meaningful community participation, nor accountability in the use of the NHI Fund.

QUESTION 2: Since the role of Clinic committees and hospital boards at district health level are prescribed in the national health Act. Is it PHM's view that Chapter five of the national health act must be amended?

PHM reply:

- It is incorrect to say that the roles of Clinic Committees are prescribed in the National Health Act. A careful reading of the Act shows that the roles and functions of Health Committees are left to provinces to legislate. In paragraph 42(3), the Act states that "*the functions of a committee must be prescribed in the provincial legislation in question.*"
- It is precisely because of this provision in the NHA that Clinic Committees are not standardised or harmonised across the country in terms of what they are expected to do and what powers they have – each province can decide for themselves. This results in very different organisational arrangements and accountability arrangements making national uniformity under an NHI very difficult. See for example, the report of the Learning Network for Health and Human Rights at UCT[2] which shows the wide variations between provinces in the roles earmarked for clinic committees in South Africa.
- Similarly, the NHA does not specify the role of Hospital Boards. It states in paragraph 41.5 that the Minister must prescribe the functions of a Central Hospital Board.
- Boards regarding hospitals other than Central Hospitals are not discussed in the NHA. It is our understanding that like Clinic Committees, Provinces legislate roles for Hospitals Board independently, and there may be substantial variability between provinces.
- In contrast, Section 31(3) of the NHA provides a detailed account of the roles of a District Health Council. However, there is no mention in this paragraph — or any related paragraphs dealing with the DHC — of any interface with hospital boards or clinic committees, when these latter structures are supposedly intended for communities to participate in health matters affecting them. This means that there is absolutely no integration of community participation structures with the DHC. While the MEC for Health may appoint up to 5 other persons to the DHC, he or she is under no obligation to appoint any representatives from clinic committees or Hospital Boards. In any event, it would be unclear how the MEC might do so in a way that is fair and secures adequate community representation since there is no formal articulation of DHCs with Health Committees and Hospital Boards.
- Accordingly, PHM SA does believe that amendment of the NHA is needed. In particular, the roles and function of clinic committees and hospital boards should not be left to the

discretion of the different provincial legislatures or even to the Minister, but should be provided for in writing and should be consistent with earlier policy papers (such as the 1997 White Paper on the Transformation of the Health Services) giving these structures clear governance and accountability roles, consistent with their location in the PHC system.

- However, reform of the NHA, whilst needed, will not solve the problem that the NHI is introducing a plural system (public and private facilities) without anticipating how community participation will provide any governance role when purchasers and providers are separated. Secondly, the introduction of a mix of public and private providers means that community participation systems need to be legislated in the private sector as well to ensure consistency. The NHA does not apply the provisions of Paragraph 42(3) to private sector facilities, nor provide any guidance for private sector hospital Boards.
- The NHI Bill therefore needs to ensure that the participation structures envisaged under the NHA are given teeth within an NHI environment, otherwise communities will be further disempowered with decisions being made by committees in which communities have no say or participation.

QUESTION 3: PHM SA's concern around Primary Health Care and Primary Care is unclear. Has the PHM familiarised itself with provisions of a the NHI White Paper regarding the service delivery model within an NHI environment?

PHM reply

- The terms Primary Care and Primary Health Care are often used interchangeably. Yet, their meanings are very different in several ways, and lack of a clear understanding of the distinction has major implications for policy development across state sectors.[3]
- ***Primary Care*** (PC) refers to the *primary level of health care delivery* within the community. It is the first contact between people and the community with the health service. It should be readily accessible to everyone close to home or places of work. It should provide personal health services related to health promotion, disease prevention, treatment of common diseases, rehabilitation, and palliative care.
- PC is based in the clinic and the community health centre. It is the local, community-based foundation of a continuum of health care delivery that extends from the household to the clinic, the local health care facilities, to the specialist and tertiary care levels within the central provincial hospitals. Well-functioning referral pathways link primary care with secondary (regional) and central (provincial) levels of health care.
- Responsibility for good PC falls within the ambit of the Department of Health.
- ***Primary Health Care*** (PHC), on the other hand, is a *broad developmental approach to health* that involves not only the health sector but a broad range of other state sectors, as well as the private sector. It includes, but goes beyond PC, mainly because it also

looks at why people get sick and addresses the social and structural determinants of health (SDH).

- The SDH include safe housing, transport, neighbourhoods and environmental conditions; lack of poverty and inequality; adequate water and sanitation; good education and literacy; decent work and income; personal safety and security; and an end to discrimination, racism and violence. Unequal access to the SDH is responsible for the large burden of disease that the health system has to deal with.
- Clearly, addressing inequality in access to the SDH lies beyond the scope of the Department of Health and the health system. For this reason PHC includes collaborative intersectoral action and meaningful community participation in all matters related to health across sectors.
- **With this distinction between PHC and PC in mind**, we now look at the use of the term Primary Health Care (PHC) in the Bill. We use italics for emphasis.

1. In the section headed **"Definitions"** the Bill defines PHC as follows: Primary Health Care means "addressing the main health problems in the community through *providing promotive, preventive, curative and rehabilitative services* and

   (a) is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the *first element* of a continuing health care process; and

   (b) in the public health sector, is *the clinic*, and in the private health sector, is *the general practitioner, primary care nursing professional, primary care dental professional and primary allied health professional*, through multidisciplinary practices".

2. **Under "Health Services Coverage"** in Chapter 2.7(2.7.d.i), the Bill says that "a user must first access health care services *at a primary health care level* as the entry into the health system" .

   In 2.7(2.7.2.c) it says that "the Fund must enter into contracts with accredited health care service providers and health establishments *at primary health care and hospital level* based on the health needs of users and in accordance with referral pathways …"

3. **Under "Benefits Advisory Committee"** in Chapter 7 (Section 25.5.a) the Bill talks about *"*the health care service benefits and types of services to be reimbursed *at each level of care at primary health care facilities and at district, regional and tertiary hospitals …"* .

4. **Under "Purchasing of health care services"** in Chapter 8 (Section 35.3) the Bill mentions that "funds for *primary health care services* must be transferred to Contracting Units for *Primary Health Care* at the sub-district level …".
5. **Section 36** mentions "… the *provision of primary health care services for personal health care* …".
6. **Under "Contracting Unit for Primary Health Care" in Section 37** the Bill refers to PHC several times. In each case it is clear that it is talking about the provision of health care services.
7. **Section 39.3.a** refers to the provision of *"primary health care services through Contracting Units for Primary Health Care"*
8. **Section 41** (Payment of health care service providers) talks about the remuneration of *accredited primary health care service providers* …".
9. **Section 55** refers to "*the district hospital linked to a number of primary health care facilities*" (55.4.b), and to *"health care service benefits, which include personal health services such as primary health care services"* (55.4.f).
10. **Section 55** also refers to "focusing on disease prevention, health promotion, *provision of primary health care services* and addressing critical backlogs;
11. A number of sections under **"Memorandum on the objects of the NHI Bill"** refer to PHC, in every instance as an aspect of health service delivery.

- **In every case,** throughout the Bill, **the term "Primary Health Care"** refers to an aspect of health service delivery, and thus **to Primary Care** rather than **the broader concept of PHC.** Nowhere does it mention the social determinants of health.
- This is as it should be, since the NHI is about transforming health services and not about the SDH. Ensuring equity in access to the SDH requires collaborative policy formulation and action across a broad range of government departments.
- But, to avoid confusion and assist the development of national policies across sectors that relate to health and human development, it is important to apply these terms correctly. The words "Primary Care" should replace "Primary Health Care" in the Bill.

Questions of Mr Mxolisa Sokatsha

QUESTION 4: PHM is of the view that the public sector is broken and the private sector is perfect. Hence PHM SA holds the view that only private facilities will be accredited under the NHI. My question is than, where does this very interesting blanket view of both the public and the private sector come from.

PHM reply:

- This reading of PHM's critique is incorrect. We have never argued that the private sector is perfect; On the contrary, PHM-SA is on record as pointing out how the private sector has undermined the public sector and does not provide the model for health care in South Africa. We wonder where the honourable member finds the word "perfect" in any of PHM's submissions associated with the private sector. We are indeed concerned that the private sector's service and its impact on the overall health system is very problematic and have a long track record of being critical of the private sector.
- That does not mean that we cannot and will not also point to the defects in the public sector – precisely because we want to see a strong public sector able to 'out-compete' private sector services. It is because we want an improved public sector that we urge the Committee and the Department to recognise the depth of the crisis in public sector infrastructure and services which will need substantial investment rather than austerity measures currently being implemented.
- We draw the Committee's attention to the findings of the Office of Health Standards Compliance, which, in its 2018-2019 report, noted that "*Of the 730 (public sector) Health Establishments inspected, 137 were compliant, while some were compliant with conditions to be addressed. Five hundred and forty-three HEs were conditionally compliant with serious concerns, and some critically non-compliant with conditions to be addressed.*" This means that fewer than 20% of public sector facilities inspected by the OHSC in 2018/2019 were fully compliant with OHSC standards.
- Notably, the improvements reported from the previous year were modest – average scores increasing by a mere 2 to 5% year on year.
- In its 2020/2021 Annual report, the OHSC noted that "*It is common cause that the public health sector* ***is not adequately funded to fulfil the service needs of the majority of South Africans*** *[our emphasis]. Crowded waiting rooms, long waiting periods even for critically needed care (such as oncology services), poorly maintained and equipped facilities, and overworked health professionals are common features of the public health sector. Maintaining quality healthcare under these circumstances requires great commitment and fine management*."
- If we have this same scenario now (which may have deteriorated in recent years as a result of the stress of the COVID-19 epidemic), and should NHI accreditation be implemented tomorrow, it is possible that up to 80% of public sector services would not gain accreditation to participate in the NHI. Moreover, since the worst performing provinces were predominantly rural provinces (North-West, Northern Cape and E Cape), it is likely that there is an inequity favouring urban health establishments being more likely to achieve accreditation than rural establishments where need is greatest.
- We believe the Portfolio Committee should view this as a matter of deep concern. Rather than denying there is a problem with the public sector, we urge the portfolio committee to name the problem as it stands – a long-standing underinvestment in the public sector has left the public sector poorly supported and vulnerable to failing to meet accreditation standards. It needs massive investment and support to ensure it can play

the role envisaged in the NHI Bill. If this does not transpire, the NHI will lead to great inequity in health care access.

QUESTION 5: Is the is there a firm proposal from PHM on how the Stakeholders Advisory Committee could be constituted with regards to being inclusive and participating.

PHM reply:

- We believe that the existing structures in the NHA require reform (amendment) to ensure that all public participation structures (clinic committees, hospital boards, district health councils, provincial health councils) in both public and private facilities are integrated in one structured design so that clinic committees (which are democratically constituted by law (which requires the NHA to be amended) can nominate representatives upward to sub-district structures, who, in turn can nominate up to the district council which also has representatives from selected hospital boards. These district health councils can nominate up to Provincial Health Councils and must then articulate with the NHI Board. This will generate a tiered and structured system for representation that is captured in law. Also see question 2 from Ms Gela above.
- Because of the plural nature of service delivery under an NHI, there may be a need for the Department of Health to explore the optimal participation design to ensure how both private and public sector services can support meaningful community participation through appropriate structures. In other words, a formative phase of experimenting with different models may be required.
- However, the principle is that there should be a bottom-up approach, and this principle should be protected by law to ensure that the community voice is heard at the highest level. Moreover, adequate resourcing for this participation must be built into legislation to ensure that genuinely elected representatives participate in these structures and to avoid the easy options of ending up with nominees who have their own transport or can easily take time off work.
- Representation upward in the system must be combined with an obligation to report back to lower levels of the system. Again, adequate resourcing for this accountability role must be built into legislation to avoid the tendency for representatives to lose touch with the constituents who placed them in their role.
- There are examples from other countries we can draw on. For example, the Brazilian SUS has a long experience of structuring community participation in health matters with clear allocation of the relative membership of these councils ensuring that 51% of members are community voices and 49% of members are of health services. No district health budget can be processed without approval of the district council, which affords citizens a very powerful say in the decision-making of the health system.
- PHM believes that the NDOH should be urgently charged with revisiting the existing provisions for public participation in the entire health system (public and private), since

currently provisions are wholly inadequate and fail to meet the requirements outlined under the Right to Health for a Health System based on Human Rights indicators.

- Without a carefully constructed building block for participation in the health system as a whole, the NHI will fail to ensure that its Stakeholder Committees provide an effective vehicle for community participation. If, on the other hand, if we can get it right to institutionalise community participation at all levels of the health system, then how to structure community participation in the NHI decisions will be easy to implement – since it should be built on existing institutionalised systems, rather than plucking a new parallel participation system out of the air.
- Lastly, we are concerned that the conception of participation remains confined to a 'Stakeholder *Advisory* Committee.' It is well recognised that Advisory Committees lack teeth and are merely there to provide advice with little traction. The extent to which the advice is taken seriously will vary depending on many factors. Moreover, putting civil society and community voice into one big pot of stakeholders will seriously dilute any community voice in key decisions. We therefore believe that the NHI Bill should be revised with a view to giving community and civil society representative meaningful participation roles consistent with earlier White Papers on the NHI, roles which appear to have been quietly dropped in the Bill.

Questions by Ms Xiaomei Havard

QUESTION 6: As the PHM believes there is no need to introduce universal health care coverage policies in South Africa, what is your view on the single payer single fund?

PHM reply:

- It is a misunderstanding to interpret our comments to argue that there is no need to introduce universal health care coverage. This is very far from what we propose in our Submission and our presentation. There has never been a more important time for the move to universal health coverage than now, as illustrated in the current pandemic.
- What we are concerned about is that the interpretation of UHC allowed by the NHI bill may result in a health system that is neither Universal nor provides Coverage, and that replaces health with health care. In other words, the NHI Bill runs this risk of failing to deliver UHC because of an undue focus on cure at the expense of prevention, and of allowing private sector interests to undermine universality.
- It is precisely to ensure universality that a single payer system is essential and is therefore one we completely support, as outlined in slide 17 of our presentation. Attempts to introduce UHC must, from the start, address the needs of the entire population and the health system as a whole[4].
    - See also the PHM reply to Mr Tshlidsi's question 21 below.

Questions by Ms Haseenabanu Ismail

QUESTION 7 : To what extent does the NHI Bill allow for equal access to health care.

PHM reply:

- The intent of the Bill is to promote equal access to health care. However, whether it will do so will depend on whether the obstacles to access are adequately addressed. We believe the Bill therefore needs reforming precisely to address those potential obstacles.
- The bill should explicitly commit to building up services in under-served areas (rural or peri-urban) to avoid the situation that wealthier, urban areas benefit from the provisions of the bill but rural and peri-urban areas are left behind.
- Portability of services should ensure that those persons living in areas with poor services are not condemned to use substandard care because they are unable to use facilities away from where they live.
- Thirdly, the current difficulties in access to health care experienced by non-South African migrants will be exacerbated under the NHI. PHM is of the position that the restrictions on access for non-citizens as framed in the NHI Bill are both highly problematic and unconstitutional.

QUESTION 8: is this an all-inclusive Bill? Would you say that the NHI Bill in its current form would be providing a health care based model? Is the NHI Bill a sustainable bill in its current form.

PHM reply:

- "No" to the first question, as we make clear in this document, "Yes" to the second — indeed the Bill is about the provision of health care, but it is an inequitable model; those who need the most care will have the least access. "No" to the third question. in the long run, nothing is sustainable in the face of enormous inequality

QUESTION 9: My second question, we know that tax space in South Africa is relatively small, do you feel that a pool of taxes will be sufficient to carry to bill to provide for effective healthcare services to the country.

PHM reply:

- We believe South Africa has much room to expand its tax base – both by eliminating corruption at SARS to ensure proper tax recovery, and by increasing taxes both on the superrich and on companies, whose relative tax levels have declined substantially since the early post-1994 period.

- Secondly, the gradual phasing out of medical aid subsidies will release substantial sums of public funds for NHI purposes.
- Lastly, the efficient deployment of financial resources will enable tax to go further than it is currently doing.

QUESTION10 : PHM SA said that infrastructure must be fixed. Now, do you feel that with the current shortage of healthcare workers placements and with the infrastructure crisis NHI would really work?

PHM reply:

- The failure to maintain our facilities is a real crisis that needs urgent attention from the NDOH. Long-neglected repair and maintenance should definitely be a priority if the NHI is to be implemented.
- The lack of a clear Human Resource for Health Plan is a huge impediment to the successful implementation of the NHI. We are deeply concerned that more than 10 years since the Green Paper emerged, the NDOH has still not finalised a HRH plan.
- Such an HRH plan should include the full range of Health Workers including Community Health Workers, workers involved in health promotion and disease prevention and health workers who are providing non-personal services that contribute to prevention at a population level (e.g. environmental health services, epidemiological surveillance).
- For that reason, we are puzzled as to why the Department of Home Affairs removed Health from the list of scarce skills positions. It would seem that at a time South African needs health workers, the NDOH should be ensuring that other government departments develop policies that support rather than undermine key population health objectives.
- The shortage of health care worker placements is a budget problem related to austerity. It is absolutely the case that an NHI cannot be implemented whilst government is trying to cut back on spending, particularly related to human resources.

QUESTION 11: Does PHM SA think we will access quality healthcare if we don't ensure first that we increase the amount of healthcare workers in the system and improve our health infrastructure before the NHI is implemented?

PHM reply:

- We have not seen any evidence of a turn-around in efforts to improve human resources for health or in the quality of health infrastructure, despite public lobbying and attention.
- We agree that there must be clear evidence of progress with attainable targets for an NHI to be considered implementable.

QUESTION 12: Does PHM SA think that a single purchaser model is going to cause a monopoly which will increase the prices of medicines?

PHM reply:

- We are not aware of any evidence that suggests that a monopsony ('monopoly of purchasing power') is associated with increasing the price of medicines. On the contrary, it is likely that the monopsony will drive down prices of medicine. There is evidence of this at the following sites:
    - A report on the German system which has single-payer drug pricing within a multi-payer health system, with lowered medicine costs compared to the USA;
    - A systematic review of economic analyses of the impact of introducing a single payer health care financing system in the US found that cost savings would be significant and that the largest contributor to this savings was due to lowered drug costs, not increased drug costs.
    - A review of primary care prescription drugs purchased in 10 High-Income countries found that drug expenditures were lower among single-payer financing systems because they led to lower prices and the selection of lower-cost treatment options.

QUESTION 13: Considering that the office of health standards and compliance presently can't manage to monitor even 20% of our healthcare facilities and affected health facilities need to reach certain compliance requirements under the NHI. PHM SA spoke about primary health care emphasis on our clinics and so many of our clinics will not meet NHI standards, does PHM feel that this will stifle or impact health services to communities?

PHM reply:

- The OHSC has a key role to ensure quality in a future health system. If it is unable to reach an adequate number of facilities, this will severely undermine the NHI and its chance of implementation. The OHSC should be adequately resourced to achieve what it is intended to do.

QUESTION 14: Under the NHI Bills current governance and organisation structure, does PHM SA recommend the private sector be included on the board to improve the accountability and the legitimacy of the board. What outside oversight measurements, does PHM SA feel should be included, so that we can mitigate the threat of corruption.

PHM reply:

- We do not believe the private sector should play any oversight role over the NHI. The private sector has its own interests and serving on any governance structure would represent a fundamentally flawed institutional design since the participants would be entirely conflicted in such a role.
- It is unclear how private sector participation could enhance the 'accountability and legitimacy' of the board. The NHI should not be accountable to providers but to the users and the public, and the structure and functioning of the board must, as first principle, ensure its accountability to the public, or elected representatives. There is no democratic system we know of that sets up a public governance structure in ways that enables accountability to private sector providers or private sector interests.
- Similarly, we believe the legitimacy of the board will stem from what it does rather than who it represents. That much is clear from the 2015 and 2017 White Papers. Unless one believes that legitimacy is conferred by the extent to which a structure is representative of different stakeholders, then the presence of private sector interests on such a board cannot be considered to contribute in any way to legitimacy. And the alternative, that a wide array of stakeholders will achieve legitimacy, will no doubt only be achievable at the expense of functionality, since it will end up being a very large structure to accommodate the many stakeholders.
- It is a fallacy to think that the private sector is in any way a vehicle for legitimacy and accountability, since the Health Market Enquiry showed very clearly the limits of the private sector's claims to efficiency and its lack of accountability.
- In short, we are strongly opposed to the inclusion of the private sector in the NHI Board.

QUESTION15: Does PHM SA feel that the bill would stifle innovation in the healthcare sector.

PHM reply:

- PHM does not believe the Bill will have any adverse impact on innovation. It may reduce speculative investment in activities that are not evidence based. Such speculative activities cannot be called 'innovation'.
- Innovative systems for health care delivery can be promoted through the NHI because a Benefits Advisory Committee can have such evidence presented to it for inclusion in the package of care covered under the NHI.
- What is needed for innovation in the health care sector is a coherent science and innovation policy that recognises the Right of Everyone to Enjoy the Benefits of Scientific Progress and its applications (Paragraph 15 of the International Covenant of Social, Economic and Cultural Rights, which South Africa ratified in 2015). Under a science system that encourages public benefit from science innovation, an NHI would thrive.

- PHM believes that for too long, innovation has been mistakenly associated with private investment and private benefit. We need to think of innovation as contributing to public goods and public benefit, as has been so clearly illustrated in the COVID-19 epidemic.

QUESTION 16: PHM SA has prioritized and mentioned the public in decision making, over and over and over in their presentation.

How does PHM SA feel the public should be more involved in the Bill, what is your recommendation, we know about health facilities and hospital committees and so forth, but really in the Bill, what would PHM SA recommend to include the public sector in the decision making.

Because if one is looking at the amount of public health care facilities,, whether it be hospitals and clinics, they are so many, how do you include each and every one or you know, on the advisory committee. How do you want this included in the Bill.

PHM reply:

- This is answered in relation to questions 2 and 5 above. In short, the NHA needs to be reformed to provide a single integrated public participation system that cascades upward from communities, right up to national structures and down again through accountability mechanisms back to communities.
- With this in place, it will become possible to fashion representative input to decision-making structures in the NHI. We do not need to invent parallel structures for participation, nor should we do so.

QUESTION 17: Does PHMSA feel that under the current NHI Bill a lot of our professionals and healthcare workers will leave the country?

PHM reply:

- There is no evidence that the NHI will lead to brain drain. The factors that lead to brain drain will not be exacerbated. If anything, the relief of pressure on public health systems because of the integration of private systems into one health care delivery platform, will reduce the drivers related to stressful conditions of work.
- Some health care workers in the private sector may well feel the security of their income is threatened and choose to leave. However, their contribution to addressing the county's burden of disease is marginal since they are already largely sequestered in the private sector and not accessible to the populations who need them most. The impact of any loss of such personnel will be compensated by the increased pool of staff becoming available to provide services to the whole population, not just the 16% serviced by medical insurance.

QUESTION 18: PHM SA highlighted the issue of special needs patients, etc. Does PHM SA feel that the referral pathways are very Labor intensive and could negatively impact timelines and adversely affect the health of patients?

PHM reply:

- The needs of the most vulnerable cannot be traded off as too costly or cumbersome to accommodate. It is a human right for persons with disabilities to receive quality care. To the extent that provision of such care is labour intensive, we acknowledge there will be costs but believe the state must find innovative ways to meet these needs.
- If innovation is the issue, this is where the private sector can contribute to joint innovation to ensure that referral pathways bring quality care for special needs patients if it has the will and the tools to do so.

Questions by Mr Munyai Tshilidzi

QUESTION 19: In the presentation was said that PHM SA is the South Africa chapter of PHM, if so, where are the head quarters . And since, in the 70 countries that they exist where do they contribute to what policy reform, did they contribute the UK, for instance, the NHS reform which is like the NHI here. Did they participate in the US Obamacare? Did they participate in Australia health reform policy. If they can give us example whether they did so if they did so if they didn't do so there then why here?

PHM reply:

- The PHM is a global network bringing together grassroots health activists, civil society organisations and academic institutions from around the world, particularly from low and middle income countries (L&MIC). We currently have a presence in around 70 countries.

  Guided by the People's Charter for Health (PCH), PHM works on various programmes and activities and is committed to Health for All through Comprehensive Primary Health Care and addressing the Social, Environmental and Economic Determinants of Health (SDH).

- Because PHM is a global network that relies mainly on volunteers, it has no headquarters. There is a small global secretariat for the movement which rotates every 3-5 years and is currently based in Latin America.
- Our central global campaign is the Health For All Campaign, which focuses not only on promoting equitable health systems, but also on the SDH through key Thematic Areas.

  Health systems and SDH differ from country to country, but the global forces that shape them are universal. For Example, vaccine apartheid blocks access to COVID vaccines in Africa; the environmental crisis is already killing people through droughts and floods and leading to migrations; the global food environment drives a growing pandemic of NCDs. Other such global forces include war, conflict, and forced migration; and gender

injustice. PHM believes it is necessary to link these global issues to people's lived experiences on the ground for a better understanding of health and its determinants.

- PHM chapters in different countries set their own agendas and address issues that are relevant to their country. In South Africa we campaign for a "People's NHI". Details of this campaign, including our submissions to the green and white papers, relevant briefing papers, information material and media releases and articles can be seen here.
- We see the NHI project as a rare opportunity to establish an equitable health system that will deliver health care to all of us according to need rather than means. Such opportunities are rare – they occur about once in a generation, only to be sacrificed at the altar of vested interests.
- The most recent one occurred in 1996 when the ANC abandoned its own 1994 Health Plan shortly after assuming power. The one before that came up in 1948, when vested interests in the private sector, professional groupings, and the provincial health departments opposed the National Health Services Commission (Gluckman Commission), making it easier for the National Party to discard it completely after winning the 1948 election, and go on to implement apartheid health care.
- Today's opportunity to build an equitable health system for all in South Africa through the NHI is on our collective watch.
- PHM has been active internationally to support Universal Access to Health Care as part of the Right to Health.
    - In the UK, PHM has worked to defend the National Health Service against its weakening by further privatisation under successive governments. Privatisation of the NHS started in the 1980s and is leading to growing inequalities in health. We believe that much of the UK NHS reform has undermined Universal Access to Health Care precisely because it introduced privatisation into a publicly funded and publicly provided health care system.
    - In Australia, PHM has campaigned for better health care for aboriginal people as part of a health system based on UHC.
    - In the US, PHM has been active in working towards a single-payer, universal health care system. The final adoption of Obamacare represented a compromise which had limited success in enhancing access to health care for people in the USA.

QUESTION 20: PHM SA raised the concern of the NHI bill to not focus narrowly on UHCoverage at the expense of the social determinants of health. Since the bill is focussing on covering personal health care services as opposed to non personal health care services, what is PHM proposing for the funding of problems aimed at addressing the social determinants. How should this be coordinated?

PHM reply:

- The Bill essentially relocates the bulk of the national health budget to the NHI Fund. If the preventive and promotive functions that address the Social Determinants of Health are not going to be addressed within the NHI Fund, then there needs to be ring-fenced protection of such funding to ensure that South Africa's health system retains the ability to address upstream determinants of health. This is not stated anywhere in the bill. (Also see PHM's reply above to question 3 from Ms Gela on the distinction between Primary Health Care and Primary Care).
- The National Health Act is being amended to accommodate the NHI Fund so that fiscal flows can reach the NHI fund. However, the functions of National, Provincial and Local Authorities that do not relate to personal health care, are not protected and so budgets are not protected.
- By way of example, taxation of health harming products (tobacco, alcohol, foodstuff with added sugar, vaping, etc) should find its way into prevention activities rather than funding health care. This could take place through an Independent Health Promotion Foundation. Or it could be channelled through the various Institutes of the National Public Health Institute of South Africa (NAPHISA). Yet the NHI Bill is silent on these matters.
- At the end of the day, if the National Department does not maintain its stewardship function, funded adequately, then health sector funding will become totally dominated by the funding of health care rather than funding health comprehensively.

QUESTION 21: . It is unclear if PHM SA implies that it asserts that UHCoverage might facilitate profiteering from the NHI fund. Which provision in the bill creates the possibility of this risk and what is the proposed change to ensure this doesn't happen? PHM SA seems to want UHCoverage without the NHI?

PHM reply:

- Universal Health Coverage means that **all people have access to the health services they need, when and where they need them**, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care (WHO). Equity is a fundamental principle of UHC.
- However, the meaning of UHC is contested by groups with vested interests in private health care delivery.
- In general, such groups favour funding for UHC through voluntary membership-based insurance schemes. People who can afford to do so join a scheme and pay monthly premiums. When they get sick the scheme covers some of the costs of some treatments (benefits) from the pooled contributions of all the members. Non-members are excluded.

- Such insurance-based systems discriminate against the poor and least healthy. Furthermore, by setting up groups with different levels of cover and risk, such scheme-based systems entrench inequality, as is the case in South Africa.[6]
- Often, as in South Africa, these schemes are state-subsidised from tax revenue. This means that the poor subsidise health care for the rich.
- There is compelling international evidence that only mandatory publicly funded universal systems can realise the objectives of universality, equity and social solidarity as intended by the NHI project. Attempts to introduce UHC must, from the start, address the needs of the entire population and the health system as a whole[7].
- Experience, especially in Latin America, shows that piecemeal, scheme-based "transitional" arrangements create groups with vested interests in the status quo. They then resist subsequent attempts to move towards unified systems. Indeed, this is the situation we confront today in South Africa where groups who benefit from the current unsustainable situation seek to shape the NHI project in their favour.

Questions by Ms Michele Clarke

QUESTION 22: I want raise an issue around the NHI grants that we receive that is mean to upgrade universal healthcare in our system. In 2020 the treasury shifted R1,4billion out of NHI in direct grants received which funds, the majority of NHI projects at the time. The Treasury said the cut was due to slow spending on contracting with general practitioners, mental health services and oncology services. Similar cuts were imposed in 2019 when R2,8billon in unspent NHI funds moved to the provinces so that they could fill critical posts.

The medium term budget policy statement now sees the Treasury cutting three and eight comma 4 million from NHI indirect grant trimming the allocations for 2021-22 financial year from 1.34 billion to 1.03 billion. The February budget allocation 7.5 billion to the NHI indirect grant over the medium term expenditure framework. This includes 986.3 million to fund contracting of health care services 2 billion to strengthen the health system in preparation for an NHI and 4.4 billion for infrastructure projects, so a year on year the NIH grants that have been given to the health department in order to strengthen our health system has not been realized.

3.8 billion Rand was spent on pilot projects the outcomes of those pilot projects have not been factored into this book as to realize positive outcome.

PHM reply:

- PHM SA views health care not as a drain on the economy, and we are opposed to austerity in allocations to public goods in general. Health care should be seen as a public good. A healthy nation is a more productive nation economically; conversely, a

more unhealthy population will be unable to generate economic and social benefits for the collective good.

- PHM SA believes that we should accept that fixing the public health system will need considerable funding, but this should be seen as an investment rather that a drain on the economy.

QUESTION 23: So access of healthcare is a right and I agree 100% everybody in our country should have access to quality healthcare.

But I also think it's a right of yours, a human right of your to choose who you would like to use within that as a healthcare provider, and it should be your choice to go for a second opinion and as my colleague spoke about referral timelines, I am concerned, you know how lengthy that process would be and would there be any recommendation from you in order to propose a referral system that would be fast and would benefit people in this country.

PHM reply:

- It is true that clause 2.5 of the National Charter for Patient's Rights[1] says

  > *Everyone has a right to choose a particular health care provider for services or a particular health facility for treatment, provided that such choice shall not be contrary to the ethical standards applicable to such health care provider or facility.*

- The Charter is a set of rules formulated by the Health Professionals Council of South Africa. It concerns the ethics of professional conduct against which to evaluate complaints of misconduct. Health professionals are obliged, in terms of professional ethics, to honour patients' choice of a provider as well as requests for second opinions.

- However, this right is not regarded as a *human right* in the way that access to health care is. It is not specified in our Constitution, nor in the International Covenant on Economic, Social and Cultural Rights or the UN Convention on the Rights of the Child, both of which are ratified by South Africa.

- A well-functioning public health system would have good, speedy (depending on urgency) referral pathways between the local Primary Care facilities through Second and Tertiary (specialist) levels of care. This happens daily in many – mainly urban – parts of the country. The challenge is to extend this to include rural and other poorly-serviced areas.

- In any event, there are few rights that are absolute and the Constitution provides clear guidance in section 36 for how rights might be limited in the interest of the public good. If a health system will expand access to underserved populations by proscribing unfettered choice of practitioner, there may be plausible human rights grounds to restrict such choices, as long as the restriction is compatible with the Bill of Rights.

[1] https://www.safmh.org.za/wp-content/uploads/2020/09/National-Patient-Rights-Charter.pdf

QUESTION 24: Do you believe that the current universal health care can be fixed and how do you suggest this is done.

PHM reply:

- We are aware that some people believe that we already have "current universal health care". They argue that medical scheme members are covered by the private sector, while everyone else has access in the public sector.
- The main problem with this argument is **inequity** – health care is accessible according to means, not according to need. Those who need the most care get the least access.
- We therefore do not agree that the current system can be plausibly described as 'universal health care' and therefore it is not a matter of fixing the current system. What is required is to fundamentally reform the whole health system, public and private, as indicated by the NHI Bill.
- This is because equity is a fundamental principle of Universal Health Coverage The Bill seeks to achieve UHC through the NHI. (See the discussions on UHC above for more detail about PHM's view on UHC).

QUESTION 25: Do you believe that the NHI Bill can realize its outcomes, with the current state of hospitals, pointing out again that only five out of 686 hospitals were compliant in the terms of the 80% ratio of the health department.

PHM reply:

- The Office of Health Standards Compliance has updated its findings in more recent reports – see our reply to Mr Mxolisa Sokatsha's above. Things have improved a little, but we agree that the state of hospitals is still not good enough for the NHI Bill to realise the intended outcomes.
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QUESTION 26: What would PHM SA suggest? Does PHM SA have some recommendations about to fix the current health care system. Is there any suggestions to ensure that the current system is upgraded, so that we can actually supply quality healthcare throughout our country.

PHM reply:

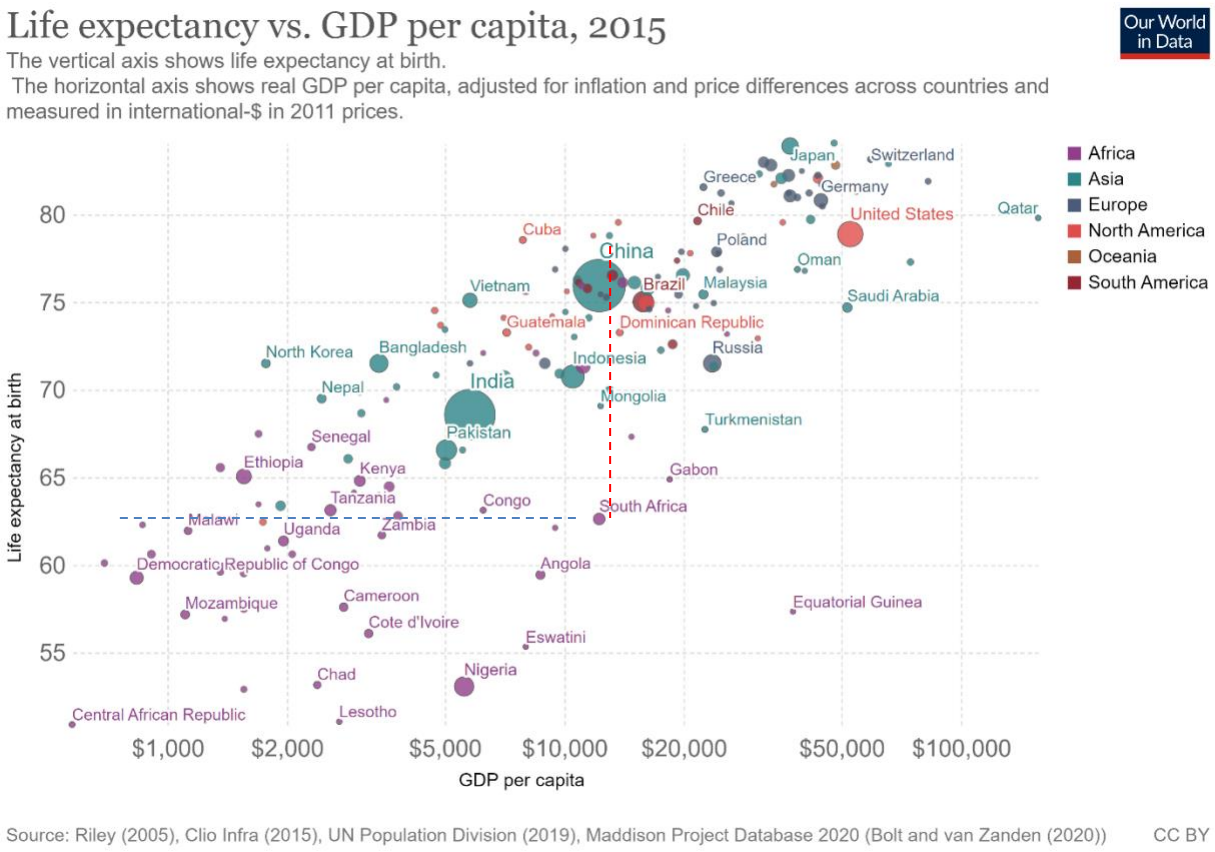
- Fixing the current healthcare system, fragmented and inequitable as it is between urban and rural, private and public, province and province, and so on, will need an enormous investment. Austerity should not be applied in the health setting since it simply leads to further deterioration of the public health sector and increasing inequality. We must find a way to harness all the health care resources available in the country to deal with our growing national health crisis – a crisis that started many decades before COVID. We

deal with other aspects related to the question in several sections above – for example, improved participation, adoption of a clear human resources for health plan and other measures.

QUESTION 27: How does PHM SA think that South Africa competes in the global health structure.

PHM reply:

- In the current environment our health system, including the hospitals, can't deal effectively with the country's burden of disease and ill health. The burden falls mainly on the public sector, while the private sector has essentially isolated itself from it and plays a relatively small part in dealing with it. This ineffective use of the ample healthcare resources available in the country, coupled with inequity in access to the SDH, means that, in the global swing of things, we compete very poorly even among middle income countries, let alone around the globe.
- For example, life expectancy is a good indicator of the health of a nation. As things stand now, the average number of years that children born in SA today are expected to live (life expectancy at birth) is less than that of a child born in the vast majority of other middle-income countries. It is similar to or worse than several countries that are poorer than we are, including African countries – for example Ethiopia, Ghana, Malawi, Sudan, Uganda, and Zambia. For the evidence on this, find 'Life expectancy vs GDP per capita' at Our World in Data.
- The figure below shows this. It compares life expectancy in relation to GDP per capita for different countries in 2015. South Africa's life expectancy (average of 62 years) is comparable to Congo, Zambia, Uganda and Malawi, whose GDP per capita is between a half to a tenth of that of South Africa (horizonal blue dashed line in the figure). Alternatively, for the wealth South Africa enjoys (average GDP per capital about US$ 12000 per annum), our life expectancy is lower than Mongolia, Dominican Republic, Brazil and China by between 6 to 15 years (vertical red dashed line in the figure).
- Therefore, for our level of wealth, our health status is very poor. Similar graphs will show that for what we spend on health (which is quite high), we get very poor health outcomes.
- This means we could do better if we spend our resources better - more equitably and more efficiently. That is what the NHI intends to do.



Source: Riley (2005), Clio Infra (2015), UN Population Division (2019), Maddison Project Database 2020 (Bolt and van Zanden (2020)) CC BY

<u>QUESTION28:</u> Would you say that if Parliament had to play a far more progressive role in terms of establishing the boards and committees, would you feel that that would make that process far more transparent?

PHM reply:

- The responsibility for establishing hospital boards and clinic committees lies with the health department. If Parliament was willing and able to call the executive to account for the lack of effective participatory structures in the health system, and to report regularly on progress in improving the situation, it would go a long way to ensuring stronger voice for communities.
- Stronger community voice will be part of improving transparency but is not the only point at which parliamentary oversight is needed. All aspects of the NHI should be subject to parliamentary oversight.

Questions by Dr Kenneth Jacobs

QUESTION 29: PHM SA raised some concerns about the fact that you believe that there are provisions of the bill that are inadequate in addressing the health care challenges of our health system, can you provide us a proposed wording of the changes that you think should be reflected in the bill.

PHM reply:

- Our concerns have been addressed in the replies we give to several questions above. We are not legal experts and wording legal instruments is not in our field of expertise. We leave that to the technical drafters of legislation.
- However, we provide here a synopsis of the key concerns we have about the Bill which we believe need revisiting if it is to address health care challenges in the health system.

  - Inadequate provisions for accountability. At the central level, the Minister has virtual total control over the NHI Fund. It should be clear from the Digital Vibes scandal that such control should never be vested in individuals or political parties, no matter who the Minister is. Accountability should be primarily to parliament which has the oversight responsibility for Chapter 9 institutions and other para-governmental bodies.

  - The Stakeholder Advisory Committee is also accountable to the Minister and not to the constituencies it is supposed to represent. At community level the Bill provides no clear mechanism for community accountability. Nor does the National Health Act in the way it deals with the various clinic and health committees. (see detailed comments above on this matter). The NHA should be amended to create a seamless system of community participation in health and the NHI Bill should be amended to articulate at all levels with this participation infrastructure.

  - The Bill has misconceptions about PHC because it fails distinguish PHC and PC. This creates the sense that the nation's health is the responsibility of the DoH and that health is primarily achieved by providing health care. This is a serious flaw.

  - In fact, promoting health and reducing the burden of disease are cross-cutting intersectoral matters. There should be "Health in All Policies" across sectors – meaning intragovernmental collaboration is essential to realise health. The Bill can easily be amended by replacing mentions of Primary Health Care with the term that describes what is intended - Primary Care.

  - The Bill lacks clarity and critical insight into the meaning of UHC, rendering it vulnerable to vested interests and jeopardising its potential to achieve equity in health care.

- A real risk of increasing inequality exists through (a) the registration process which makes it more difficult for rural and other vulnerable group to obtain NHI registration; (b) an absence of systems to ensure public sector service quality is systematically improved.

- A clearly articulate Human Resources for Health Policy is needed to complement the NHI Bill and should be stipulated in the Bill. It should be evidence-based and regularly updated.

QUESTION 30: PHM SA highlighted that there is a lack of detail about updating the public sector. Do you delineate between the jurisdiction of the objects of the national health act against the objects of the NHIbill?

PHM reply

- We are not sure if we understand this question correctly but think the honorable member is asking about how the NHA and the NHI Bill should be harmonised. The existing NHI Bill provides for a number of reforms to the NHA in different places. We agree that the NHA will need substantial reforms. However, an accompanying memorandum to the NHI Bill should have clarified how the Department foresees the different roles of National and Provincial Health Departments under an NHI – viz, roles such as stewardship, coordination, policy, surveillance, planning, evaluation and other core functions. There are still too many unanswered questions as to what will happen to the 'rump 'of the health department if it's not a service delivery component. Moreover, it is unclear what role, if any, will be left to Provincial health departments. For that reason, an explanatory memorandum of some depth would be needed to understand how harmonisation could occur.
- Further, there are other related pieces of legislation not addressed by the NHI Bill, such as the National Public Health Institute of South Africa Act. It is unclear how the NAPHISA and its sub-institutes will interact with the NHI Fund. This will need additional regulatory harmonisation.

QUESTION 31: PHM SA raises that an incremental approach to the implementation of the NHI would be opposed were previously received submissions from some of the dominant players in the private sector cautioning the committee on an accelerated phase of implementation of the NHI.

How do you respond to this view of the private sector that I just mention?

PHM reply:

- This concern relates specifically to the implementation of UHC. See our reply to Ms Ismail's question 21 above. The key issue is that a piecemeal approach with different schemes for different people creates and perpetuates groups with unequal benefits. Those with a greater share of the benefits resist change to more equitable systems.
- PHM is aware that moving quickly to a unitary, whole population, whole health system will be difficult in SA, where inequity in health care risks and benefits are massive. But, with this in mind, the Bill should be explicit about the intention to creating a publicly financed unitary, health service with legislated steps and deadlines.

QUESTION 32: Can PHM SA provide examples of countries where they are waiting for the system to be fixed before they could implement the financing legislation and is it not essential that through the NHI the financing of our system improves to achieve the weaknesses ?

PHM reply:

- We do not understand the use of the term "waiting for the system to be fixed." That our system needs fixing should be evident to all. It is not a question of waiting; it should be a question of doing, and doing it as quickly as possible.
- However, despite the need for resuscitating the public sector having been raised with the Department and with Parliament over the last decade since the NHI has been on the table, we have not seen a serious commitment to building the public sector. We need to hear a commitment articulated clearly from the national department that the public sector will be strengthened and we need to see concrete evidence of progress.
- We point out that the NHI project will not succeed unless there is a functioning health system. We do not argue for an approach that sets up a contradiction between fixing the system on the one hand and developing and implementing the legislation on the other. We see these as mutually reinforcing processes that approach obstacles jointly. Neither will work unless the other works. However, whenever we raise the need to fix the public sector, we are met with an unwillingness to embrace the need to focus on improving it. Worse still, we are accused of positions we do not hold – such as the idea we want to 'wait' for the system to be fixed.
- The bottom line is that nothing will work for an equitable NHI unless public money is used for the public benefit and not looted.

Questions by Ms Magdalena Hlengwa

QUESTION 33: I have two seeking clarity questions number one you speak about the unequal decision making powers. Can you elaborate on that so that we are all on board?

PHM reply:

- We deal with this in several questions around the issues of accountability above.

QUESTION 34: PHM SA talks about primary health care it be important and PHM SA continues saying meaningful Community participating in issue related to health. What about the public hearing in the provinces, we do meet the clinic committees, but you are going to tell us more about what you mean about this.

PHM reply:

- The Parliamentary Committee cannot do the work of the Health Department. It is the health department's job to ensure there is meaningful participation in the health system and the role of the Portfoliio Committee is to hold the Department to account for effecting meaningful community participation. That participation is not happening now and the Portfolio Committee appears unaware of the poor state of participation structures in the health system currently.
- The fact that the Parliamentary Committee has received input from health committees is to be welcomed. But that cannot compensate for the lack of a system of meaningful participation by communities.
- Please refer to Ms Gela's question 2 above, where we deal with the issue of community accountability in detail.

QUESTION 35: . Can PHM SA clarify what they mean with rubber stamping, are we rubber stamping buy doing this hearing.

PHM reply:

- PHM does not mean to imply that this process of consultation around the NHI is rubber stamping. We apologise if that impression was given. It is clear the Committee has made considerable efforts to take input from the public and for that we acknowledge the hard

work and commitment of the Committee, and the honourable intentions of all its members.

- There is, however, a wider context for participation in South Africa where consultation is done for the compliance with the law and where decisions are already made by the time consultations are done. Our concerns about rubber stamping relate to how decisions will be made in the NHI. If the Stakeholder Advisory Committee has no real power to influence decisions, then it will be the case that the stakeholders' involvement will be rubber stamping decisions already made. This is the concern PHM brings to the Parliamentary Portfolio Committee.

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[1] See: https://study.com/academy/lesson/what-is-a-civil-society-definition-examples.html

[2]http://www.salearningnetwork.uct.ac.za/sites/default/files/image_tool/images/386/publications/other_reports/output_1_rapid_appraisal_dec_2013-2.pdf

[3] See: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6976192/pdf/41997_2006_Article_BF03405354.pdf

[4] For a detailed analysis of funding for UHC and what it means for policy see the article by Joseph Kutzin from the Department of Health Systems Financing at the WHO here:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3738310/

[5] The WHO definition of UHC: Universal health coverage means that **all people have access to the health services they need, when and where they need them**, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

[6] See: https://pubmed.ncbi.nlm.nih.gov/22388498/

[7] For a detailed analysis of funding for UHC and what it means for policy see the article by Joseph Kutzin from the Department of Health Systems Financing at the WHO here:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3738310/